Medical Care – And How

FOR almost two years a committee of the American Public Welfare Association, Judge Thomas S. J. Waxter of Baltimore, chairman, has been engaged in a study of administration of tax supported medical care for the sick poor. [See Medical Care—But How? by Gertrude Sturges, M.D., *Survey Midmonthly,* May 1938.] Extensive field surveys revealed "a pattern confused in its professional and administrative aspects, inadequate to present responsibilities."

To meet the need for some formulation of basic policies of organization and administration as a guide to developing programs, the committee, after extensive discussions with federal and national agencies, framed a statement, cautiously called "tentative," of "essentials and principles" which was formally approved by the board of directors of the APWA at its last meeting. The committee will continue its studies, particularly of methods of rendering tax supported medical services.

PRINCIPLES OF ORGANIZATION AND ADMINISTRATION

1. It is essential that the administration of all preventive and curative service provided directly by tax funds, as well as the administration of all payments from tax funds to non-governmental medical agencies and practitioners, be closely related and functionally coordinated. Although it is recognized that in many jurisdictions it is impracticable at the present time to consolidate the administration of all tax supported preventive and curative medical service in a single governmental department, it is essential that coordination and integration of the medical care administered by different departments be obtained through one or more of the following or other measures:

a. The development of a cooperative relationship whereby the welfare or other department charged by law with providing medical care obtains service or technical supervision through the department of health and pays for such service accordingly.

b. The official use of the state or local health officer, by *ex-officio* appointment or otherwise, in an advisory capacity to welfare or other department carrying the major responsibility for tax supported medical care.

c. The organization of representatives of the governmental agencies concerned with medical care and welfare into an interdepartmental committee, for joint planning of official programs and conference with non-governmental agencies and the medical professions. Membership in interdepartmental committees should include governmental agencies responsible for providing preventive or curative service in general or special hospitals, clinics or in the home; and those responsible for furnishing medical care to special groups e. g., children, the blind.

d. The utilization of a medical officer on the staff of the welfare department or other governmental agency primarily concerned with the administration of medical care, in a liaison capacity with other governmental departments as well as with the non-governmental agencies and the medical and allied professions concerned.

2. The function of the federal authority should be to assist with financial and technical aid and with the maintenance of standards, rather than to administer service. The state authority should be responsible either for enough assistance to and supervision of local administration to insure sufficient service and good standards or for administration on a statewide basis.

Local administrative units should be large enough to permit effective and economical administration: this will require organization on a countywide basis, or of a group of counties on a regional basis established by state authority or by cooperative agreement.

3. In planning for and administering service, the governmental authority should consult with representatives of the medical and allied professions (physicians, dentists, nurses, medical social workers and pharmacists); of both governmental and non-governmental health and welfare agencies and organizations, including hospital and health council and councils of social agencies; and of the groups to be served.

4. The governmental authority should have responsibility for policy, organization and administration. Appropriate advice with regard to the purely professional aspects of service should be sought from representatives of the medical professions.

a. Advice should be sought from each professional group, in its own field, for the formulation of professional policies and standards and of minimum qualifications for the practitioners and agencies who provide service.

b. The governmental authority should be responsible for the adoption of acceptable standards and qualifications; and for their maintenance by means of professional supervision.

5. Medical programs should be under the direction of qualified salaried medical officers of the governmental authority, appointed on the merit basis.

All professional service should be under the immediate supervision of qualified members of the profession concerned, appointed and remunerated by the governmental authority.

6. To be effective, medical care must be part of an adequate program of assistance. Public medical care must, therefore, be planned in relation to, and closely integrated with a general assistance program providing adequate food, shelter, clothing, and other essentials. Medical and social treatment for the patient should be closely correlated.

7. Existing facilities and agencies should be utilized as fully as is consistent with good quality of service and economy, and new facilities developed only where needed.

8. Reasonable methods and rates of payment should be determined by the governmental authority after consultation with representatives of the professions and agencies concerned.

9. Payment to non-governmental agencies, such as hospitals and nursing associations, should be based on authorized service rendered to individuals.

10. The governmental authority which pays for service should be responsible for authorization of care at public expense. Persons already accepted for maintenance at public expense should be accepted, without further investigation, for medical care at public expense.

The determination of medical need should be a medical responsibility and should precede the determination of financial eligibility. Determination of eligibility should not delay necessary treatment. Policies concerning determination of eligibility should be made by the public authority after consultation with the agencies and professions concerned; and should include agreement between agencies to avoid duplication of investigation.

11. The governmental authority should require records of professional service and expenditure from the organizations, individuals and agencies concerned in providing service, those records to be utilized for purposes of professional and administrative control, for the correlation of medical and social treatment, for future planning and, with safeguards for confidential matters, as a basis for public information.

The Common Welfare

"Children in a Democracy"

IN 1940, as ten years ago, a White House Conference (January 18 to 20) calls together national leaders from many fields to consider the nation's children—the gains in knowledge about child health and well-being, what we are doing and failing to do for the oncoming American generation. As it did in 1930, the U. S. Children's Bureau has organized the conference and the various special committees that have brought together materials to serve as the basis of discussion, and of plans for action.

Because of its bearing on the future of "children in a democracy" and its import for every aspect of child life in America, *Survey Midmonthly* will devote its February issue, enlarged and illustrated, to a full report of the conference, to its findings and the program of action which it will develop.

Local Responsibility

CLEVELAND made temporary truce with its relief problem by means of $1,050,000 in bonds against delinquent taxes, issued by permission of the Ohio State Board of Tax Appeals. This does not cut the knot of local and state responsibility for human suffering. Nor is Toledo's action in digging up $273,000 for direct relief and WPA sponsorship any more of a solution.

By the time the Ohio relief crisis became national front-page news, political charges and counter charges had cropped out so virulently that it was difficult to ascertain what was what. Certain facts, however, were not denied by anyone: 16,000 childless "employables" had been dropped from the Cleveland relief rolls in November and the allowances of 44,000 others had been cut to the equivalent of 5½ cents a meal. Earlier, nearly 6000 cases, out of a total of some 8500, had been dropped from the Toledo relief rolls. "Nobody is starving," said the politicians, but evidences of undernourishment, disease and mental breakdown directly attributable to insufficient food could not be denied.

Ironical was the fact that the Cleveland and Toledo crises occurred at a time when business indices in both cities were curving upward. In Toledo, October residential building was 280 percent above the year before. Yet the city could not furnish relief to its needy, nor continuous education to its children. Knowing the situation, the citizens went to the polls in November and voted down both relief and school tax levies.

Blame for the relief crises cannot be laid entirely to the cities of Ohio as their taxing power is restricted to levies on real estate. Here was a repetition of the old urban-rural fight: the cities clamoring for use of their own revenue resources either through broader powers of taxation or through further state grants; the rural areas resenting every cent of state funds spent by the cities and jealously guarding the state's tax resources. Cleveland's share of the state's $10 million relief appropriation was about 38 percent of the city's eleven months' relief expenditure of $5,807,149, although the law allows the state to contribute up to 50 percent of money expended. Governor Bricker defended the "rural side" by refusing to call a special session of the legislature to grant more state funds or extend the cities' taxing powers.

One fact clearly demonstrated by the whole miserable affair is that the solution of the relief problem is not cessation of relief. Out of 155 dropped cases investigated by the Cleveland chapter of the American Association of Social Workers, only six persons had found jobs in private employment.

While Cleveland and Toledo got national attention for their acute relief problems, similar situations resulting from "local responsibility" are chronic in countless communities throughout the country where direct relief means only a federal dole of surplus commodities. When three counties in Nebraska flounder along without general relief of any kind, the out-of-state papers take no notice. Differences in living costs do not account for the inequitable spread of relief allowances throughout the country. Average payments by state and local governments vary from $3.38 per month in Oklahoma to $34.28 in New York. It is a strange time for the Chamber of Commerce of the United States to advocate the termination of the federal work relief program.

A Vast Problem

SPAIN, China, Czechoslovakia, Poland and now Finland. We in America have risen to every occasion with relief funds and medical supplies. How many more "occasions" there will be no one knows, but few are optimistic enough to believe that Finland will end the list. This, however, is no deterrent to American generosity for the sufferers in the little country known to us chiefly for its leading musical composer, its cooperatives and its prompt debt payments. Less than a month after the first Russian bomb hit Helsinki an American fund-raising organization for Finnish war relief, under the direction of Herbert Hoover, had gone into vigorous and successful action and the American Red Cross had appropriated $250,000 for the new cause. Of this, $138,746 had been expended by January 1.

Unhappily the appearance of a new need does not obliterate an old one, rather it aggravates the older one through unconscious competition. Scarcely had the American people sensed the human import of conditions in Poland than their imagination was captured by the holocaust in Finland. In the meantime Spanish and Chinese war victims became "old hat," although thousands of Spaniards remain in French concentration camps and Chinese skies continue to rain Japanese bombs.

This espousal of cause after cause by the American public springs from a sincere desire to help where help is needed. What is surprising is that the quick succession of "causes" has not completely overwhelmed generous impulses. It has created confusion of course, but there are signs of order emerging. Under an agreement between Mr. Hoover's organization, the Finnish Relief Fund, and the American Red Cross, the fund will undertake the mass feeding of homeless Finns while the ARC will provide medical aid, hospital supplies and clothing. Meanwhile relief efforts for Poland tend toward integration as many of the scattered Polish-American fund raising groups—a month ago 208 were registered with the Department of State—are pooling their